MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6777

Reg. Dist. No. 06743

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester - Rural
c. LENGTH OF STAY IN 1b: 14 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Baslow Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Manchester Rural
d. STREET ADDRESS: Baslow Road
e. IS RESIDENCE ON A FARM? YES X NO ☐

3. NAME OF DECEASED (Type or print): First: Earl — Middle: Augustus — Last: Alban

4. DATE OF DEATH: Month: June — Day: 9 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 29, 1895

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer.

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eli Webster Alban

14. MOTHER'S MAIDEN NAME: Laura Armacost

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: none

INFORMANT: Mrs Ethel Alban, Address: Manchester Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Chronic Myocarditis.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Cardio Vascular Disease

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: ?

443 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Polycythemia Rva.

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1, 1950, to June 9, 1960, that I last saw the deceased alive on June 9, 1960, and that death occurred at 11:57 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph E Bush M.D. — ADDRESS (Street, city or town, state): Hampstead Maryland — DATE SIGNED: 6/10/60

PHYSICIAN'S NAME (Type): Joseph E. Bush MD — HAMPSTEAD MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-12-1960

22c. NAME OF CEMETERY OR CREMATORY: Hampstead

22d. LOCATION (City, town, or county) (State): Carroll Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edw A Tipton — ADDRESS: Hampstead Md

24a. REC'D BY REGISTRAR DATE: JUN 14 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kuhns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6778

CERTIFICATE OF DEATH

06744

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3 mos. 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Emmitsburg
d. STREET ADDRESS: ----------
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

10X-2

3. NAME OF DECEASED (Type or print): First: Andrew; Middle: ; Last: Annan

4. DATE OF DEATH: Month: June; Day: 24; Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 15, 1876

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): clerk in drug store

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert L. Annan

14. MOTHER'S MAIDEN NAME: Alice Colombia Motter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): -------

16. SOCIAL SECURITY NO.: 220-16-2370 A

17. INFORMANT: Springfield Hospital Records, Sykesville, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years
420.0
DUE TO
(b): Generalized arteriosclerosis — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Severe nephrosclerosis — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS. assoc. with cerebral arteriosclerosis, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from March 16, 1960 to June 24, 1960 that (I) (we) last saw the deceased alive on June 23, 1960, and that death occurred at 3:05 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Ellis S. Margolin, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: June 24, 1960

22c. PHYSICIAN'S NAME (Type): Ellis S. Margolin, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/27/60

23c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery

23d. LOCATION (City, town, or county) (State): Emmitsburg, Frederick Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: C. E. Wilson

ADDRESS: Emmitsburg Md

25a. REC'D BY REGISTRAR DATE: JUN 27 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kramer

C. E. Wilson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6779 **CERTIFICATE OF DEATH** 06745

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster
c. LENGTH OF STAY IN 1b 88 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster RD #4

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster Md. RD #4
d. STREET ADDRESS Hook Road e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First MAYBELLE Middle L. Last ARNOLD
4. DATE OF DEATH Month June Day 29 Year 1960
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH Feb. 23, 1872
9. AGE (In years last birthday) 88 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Andrew Jackson Logue
14. MOTHER'S MAIDEN NAME Mary Emily Ward
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Address Mrs. Dorothy A. Lester, Westminster Md RD #4

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nephritis (due to)
DUE TO (b) Myocarditis (due to)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Uremia
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 19 36, to June 29, 1960, that I last saw the deceased alive on June 27, 1960, and that death occurred at 5:30 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE Wm C Jeanette M.D. ADDRESS (Street, city or town, state) Westminster Md DATE SIGNED 6-30-60
PHYSICIAN'S NAME (Type) Wm C. Jeanette MD Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 7/2/60
22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery
22d. LOCATION (City, town, or county) (State) Rural, Westminster Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers Jr. ADDRESS Westminster, Md
24a. REC'D BY REGISTRAR DATE JUL 5 '60
24b. REGISTRAR'S SIGNATURE Charles S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

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8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6780

Reg. Dist. No. 16746

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr. 8mths 9dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George 16
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland 16 24.2
d. STREET ADDRESS: 4615 Porter Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mabel — Middle: Oma — Last: Beach
4. DATE OF DEATH: Month: 6 — Day: 5 — Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-11-1929
9. AGE (In years last birthday): 31 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clarence Moreland Venable
14. MOTHER'S MAIDEN NAME: Katherine Rosetta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hospital record — Address: Sykesville, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Suffocation (during an epileptic seizure) — INTERVAL BETWEEN ONSET AND DEATH: minutes
353.3
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.asso.with convulsive disorder without qualifying phrase
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.
EXAMINER'S NAME (Type): JAMES T. MARSH
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6/5/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/9/1960
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Suitland Rd. Pr. Geo. Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W.W.Chambers Co. 517--11th St. S.E. Wash. DC
24a. REC'D BY REGISTRAR DATE: JUN 8 '60
24b. REGISTRAR'S SIGNATURE: Cathryn S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6781 06747

CERTIFICATE OF DEATH

Item 4 & 9 Film 0264 6/15/60 iwk

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2wks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pallen Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis (Cape St-Claire) 02X-2
d. STREET ADDRESS: Skyway & Bayview Rds.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: John — Middle: — Last: BOOKER

4. DATE OF DEATH: Month: June Day: 8 Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 10 Jan 1880

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory man

10b. KIND OF BUSINESS OR INDUSTRY: Fleischmann Distillery

11. BIRTHPLACE (State or foreign country): Balto., Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Booker

14. MOTHER'S MAIDEN NAME: Clara Raegler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: 212-20-2324

17. INFORMANT: Mrs. Marie Zepp
Address: Rt-4 - Box 195 Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis, Arteriosclerosis
260 X
DUE TO (b): diabetes Mellitus severe, Cardiac failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): ———

INTERVAL BETWEEN ONSET AND DEATH: 1959 to 8 June 60

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-28, 1960, to 8 June, 1960, that (I) (we) last saw the deceased alive on 8 June 1960, and that death occurred at 2.3 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Howard E. Hall M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8 June 60

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11 June 1960
23c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.
23d. LOCATION (City, town, or county) (State): Balto., Md.

24. FUNERAL DIRECTOR'S SIGNATURE: R F Singleton
ADDRESS: Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: JUN 13 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

06748

6782

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: 8 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
d. STREET ADDRESS: Ridgely Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EFFYE Middle M. Last BRANDENBURG

4. DATE OF DEATH: Month June Day 22 Year 1960

5. SEX: F.
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 27 1875
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Joseph R. Musser
14. MOTHER'S MAIDEN NAME: Amanda E. Lowe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Address: Mr Wallace Sauerwein - Sykesville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis, Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1956
DUE TO (b): Heart disease, Cardiac failure. — to
DUE TO (c): Arteriosclerosis, Chronic Urinary System — 22 June 60

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1956, 19 to 22 June, 1960, that (I) (we) last saw the deceased alive on 22 June 1960, and that death occurred at 6 P.M. from the causes and on the date stated above

22a. SIGNATURE: Howard E Hall M D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 23 June 60
22c. PHYSICIAN'S NAME (Type): HOWARD E. HALL
22d. ADDRESS: SYKESVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-25-60
23c. NAME OF CEMETERY OR CREMATORY: Mt View
23d. LOCATION (City, town, or county) (State): Ilchester, Howard Co., Md

24. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight — ADDRESS: Sykesville, Md.
25a. REC'D BY REGISTRAR DATE: JUN 27 '60
25b. REGISTRAR'S SIGNATURE: Arthur S Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6783

CERTIFICATE OF DEATH

0674;

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 19 MONTHS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If inst tut'on: Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~Union Town~~ CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X UNIONTOWN
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alpheus; Middle: Wilson; Last: Brown

4. DATE OF DEATH: Month: June; Day: 11; Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/4/67

9. AGE (In years last birthday): 92 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; M.n

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dispatcher

10b. KIND OF BUSINESS OR INDUSTRY: TRANSIT

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Brown

14. MOTHER'S MAIDEN NAME: Mary Biddleson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Address: Springfield State Hospital, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular disease — Interval between onset and death: Years
DUE TO
(b): Bronchopneumonia — Days
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS associated with cerebral arteriosclerosis, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour o. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from May 31, 1960, to June 11, 1960, that (I) (we) last saw the deceased alive on June 11 1960, and that death occurred at 1.35 p.m. the causes and on the date stated above.

22a. SIGNATURE: Ellis S. Margolin, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: June 11, 60

22c. PHYSICIAN'S NAME (Type): Ellis S. Margolin

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6/14/60
23c. NAME OF CEMETERY OR CREMATORY: METHODIST CEM.
23d. LOCATION (City, town, or county) (State): UNIONTOWN MD.

24. FUNERAL DIRECTOR'S SIGNATURE: D W Hartman & Sons
ADDRESS: New Windsor Md

25a. REC'D BY REGISTRAR: DATE JUN 14 '60
25b. REGISTRAR'S SIGNATURE: Arthur E. Kinna

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6784 0675

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md b. COUNTY Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville

c. LENGTH OF STAY IN 1b 20 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville X

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First NELLIE Middle CLIFTON Last BROWN

4. DATE OF DEATH Month June Day 24 or 1960

5 SEX F.

6 COLOR OR RACE W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH 3-20-1893

AGE (In years last birthday) 67 yrs.

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Harrison

14. MOTHER'S MAIDEN NAME Ella James

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —

16 SOCIAL SECURITY NO none

17. INFORMANT Address Mr Thomas J. Brown - Sykesville, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH 1455

DUE TO (b) Arteriosclerotic Heart Dis. Cardiac — 7D

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Cirrhosis, Alcoholic, Interstitial pneumonia — 24 June 60

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 1955 19 to 24 June 1960 that (I) (we) last saw the deceased alive on 24 June 1960 and that death occurred at 7 P.M. from the causes and on the date stated above.

22a SIGNATURE Howard E. Hall M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED 6-25-60

22c PHYSICIAN'S NAME (Type) HOWARD E. HALL

22d. ADDRESS SYKESVILLE, MD.

23a BURIAL, CREMATION, REMOVAL (Specify) Burial

23b DATE THEREOF 6-29-60

23c NAME OF CEMETERY OR CREMATORY Springfield

23d LOCATION (City, town, or county) (State) Sykesville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Luther H. Haight Sykesville, Md.

25a REC'D BY REGISTRAR DATE JUN 28 '60

25b REGISTRAR'S SIGNATURE Arthur S. Kness

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6785 **CERTIFICATE OF DEATH** Reg. Dist. No. 0675

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WOODBINE, MD.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ROUTE #1, WOODBINE, MD.

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WOODBINE, MD
d. STREET ADDRESS: ROUTE #1, WOODBINE, MD.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First MINERVA Middle BELLE Last CARTER

4. DATE OF DEATH: Month JUNE Day 4, Year 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: UNKNOWN
9. AGE (In years last birthday): ABOUT 79 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK.
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: LLOYD N. KIDD
14. MOTHER'S MAIDEN NAME: MARGARET S. RILEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
INFORMANT Address: DOROTHY KURSEVICH - WOODBINE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Thrombosis, Acute — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO (b): Auricular fibrillation — 9 days
DUE TO (c): Generalized Arteriosclerosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Asthma, Cardiac,

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour ___ a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 19, 1960, to June 4, 1960 that I last saw the deceased alive on May 26, 1960, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Sami Okutman M.D. — ADDRESS (Street, city or town, state): 37 Central Ave. — DATE SIGNED

PHYSICIAN'S NAME (Type): Sami A. Okutman. Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/7/60
22c. NAME OF CEMETERY OR CREMATORY: PINE GROVE
22d. LOCATION (City, town, or county) (State): BALTO CO, MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Austin E. Bowman - 3818 Roland Ave
24a. REC'D BY REGISTRAR DATE: JUN 7 '60
24b. REGISTRAR'S SIGNATURE: Clifton S. Kinna

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6785 — 66752

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, or any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

M

I

1. PLACE OF DEATH
   a. COUNTY: Carroll
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
   c. LENGTH OF STAY IN MARYLAND: 18 yrs
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 7

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
   d. STREET ADDRESS: Route 7
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ALVIN; Middle: ROYER; Last: COLEMAN

4. DATE OF DEATH: Month: June; Day: 8; Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 29 1917

9. AGE (In years last birthday): 43 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver

10b. KIND OF BUSINESS OR INDUSTRY: Feed Co

11. BIRTHPLACE (State or foreign country): Carroll Co, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Oliver B. Coleman

14. MOTHER'S MAIDEN NAME: Alice Royer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes World War II

16. SOCIAL SECURITY NO: 214-07-4301

17. INFORMANT: Address: Mrs A.R. Coleman, Westminster Md Rt#7

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH

420.0

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic heart disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☐. Inquiry ☐. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐.

ACTUAL SIGNATURE: W Bradley King Jr M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 6/8/60

EXAMINER'S NAME (Type): W. Bradley King, Jr., M.D. Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/11/60

22c. NAME OF CEMETERY OR CREMATORY: Westminster Cemetery

22d. LOCATION (City, town, or country): Westminster Md (State)

23. FUNERAL DIRECTOR: J. L. Myers, Jr. ADDRESS: Westminster Md.

24a. REC'D BY REGISTRAR: DATE JUN 13 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6787

CERTIFICATE OF DEATH

0C753

1. PLACE OF DEATH
a. COUNTY: CARROLL
MARYLAND

2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SYKESVILLE
c. LENGTH OF STAY IN 1b: 10 weeks
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SPRINGFIELD STATE HOSPITAL
d. STREET ADDRESS: 729 ARGYLE ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FLORENCE Middle JULIA Last COOPER
4. DATE OF DEATH: Month JUNE Day 4 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-2-86
9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse & Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: Child Care
11. BIRTHPLACE (State or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Schuler
14. MOTHER'S MAIDEN NAME: Elizabeth McMichael

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 087-26-8017
17. INFORMANT: Frank J. Cooper, 729 Argyle Road, Silver Spring

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Infarction of myocardium due to arteriosclerotic coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

DUE TO (b): A.S.C.V. Disease with arterial hypertension — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): NO
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour ___ a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-18-60 to 6-4-60, 19__, that (I) (we) last saw the deceased alive on 6-3-60, 19__, and that death occurred at 5,25 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Heinz H. Klaatsch M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 6-4-1960

22c. PHYSICIAN'S NAME (Type): HEINZ H. KLAATSCH M.D.
22d. ADDRESS: SPRINGFIELD STATE HOSPITAL, SYKESVILLE

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE THEREOF: 6/4/60
23c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CREMATORY
23d. LOCATION (City, town, or county) (State): PRINCE GEO. COUNTY, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zuska
ADDRESS: [illegible] FUNERAL HOME, INC. SILVER SPRING, MD.

25a. REC'D BY REGISTRAR DATE: JUN 9 '60
25b. REGISTRAR'S SIGNATURE: Clifton L. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6788

06754

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr. 8mos. 9dy.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Annapolis
d. STREET ADDRESS: 110 Forbes Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Howard — Last: Davis

4. DATE OF DEATH: Month: June — Day: 19 — Year: 1960

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: June 15, 1904
9 AGE (In years last birthday): 56 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Davis
14. MOTHER'S MAIDEN NAME: Lola Blanche Ward

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): ———
16 SOCIAL SECURITY NO.: 214-05-0965
17. INFORMANT (Address): Springfield Hospital Records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of mediastinum
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic Reaction, paranoid type, Pulmonary Tuberculosis.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from October 10 19 58 to June 19 19 60, that (I) (we) last saw the deceased alive on June 19 19 60, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

22a SIGNATURE: Ellis S. Margolin M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: June 19, 1960
22c PHYSICIAN'S NAME (Type): Ellis S. Margolin, M.D.
22d. ADDRESS: Springfield State Hospital, Sykesville, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-22-60
23c NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial
23d LOCATION (City, town, or county) (State): Annapolis Md.

24 FUNERAL DIRECTOR'S SIGNATURE: John W. Taylor Sons
ADDRESS: Annapolis Md.
25a REC'D BY REGISTRAR DATE: JUN 22 '60
25b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6789 — **CERTIFICATE OF DEATH** — 06755

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 221 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rhodesdale
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First: Samuel — Middle: Irvin — Last: Dockins

4. DATE OF DEATH: Month: June — Day: 16 — Year: 1960

5 SEX: Male
6 COLOR OR RACE: Negro
7 MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: June 3, 1891
9 AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Steve Dockins
14. MOTHER'S MAIDEN NAME: Ida Farrar

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT: Samuel I. Dockins-Pt. Address: Rhodesdale, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiovascular insufficiency — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Pulmonary hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Far advanced pulmonary tuberculosis

002X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19 WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Nov., 8 1959, to June 16, 1960, that (I) (we) last saw the deceased alive on June 16 1960, and that death occurred at 4:45P M, from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M.D. — ATTENDING PHYS. [ ] MED DIRECTOR [X] STAFF PHYS. [ ]
22b. DATE SIGNED: 6-16-60
22c PHYSICIAN'S NAME (Type): Dr. Edgars M. Maculans, Supt.
22d ADDRESS: Henryton, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Rem-Burial
23b DATE THEREOF: 6/21/1960
23c NAME OF CEMETERY OR CREMATORY: Thompsontown
23d LOCATION (City, town or county) (State): Dorchester Co. Md

24 FUNERAL DIRECTOR'S SIGNATURE: Herbert M. Hall
ADDRESS: Cambridge Md
25a. REGISTERED NUMBER: 2130
DATE: JUN 20 '60
25b REGISTRAR'S SIGNATURE: Arthur L. Hearn

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06756

CERTIFICATE OF DEATH

Reg. Dist. No. 6790

1 PLACE OF DEATH a COUNTY Carroll MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Uniontown
c. LENGTH OF STAY IN 1b 50 yrs
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ✓

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE Maryland b COUNTY Carroll
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Uniontown
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First ANNIE Middle M Last FOLTZ
4. DATE OF DEATH Month June Day 16 Year 1960

5 SEX F
6 COLOR OR RACE W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH Feb 28 - 1871
9 AGE (In years last birthday) 89 yrs
IF UNDER 1 YEAR Months Days Hours M.n
IF UNDER 24 HRS Hours M.n

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13 FATHER'S NAME John W Hersh
14 MOTHER'S MAIDEN NAME Magdalena Trout

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
INFORMANT Address Mary Foltz, Uniontown Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 days

DUE TO (b) Arterio-Sclerosis — 1540.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from June 1960, to June 16 1960, that I last saw the deceased alive on June 15 1960, and that death occurred at 7 a M, from the causes and on the date stated above.

ACTUAL SIGNATURE M.C. Porterfield M.D
ADDRESS (Street, city or town, state) HAMPSTEAD, MD
DATE SIGNED 6/17/60

PHYSICIAN'S NAME (Type) M.C. Porterfield Hampstead, Md.

22a BURIAL CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF 6-19-60
22c. NAME OF CEMETERY OR CREMATORY Manchester
22d LOCATION (City, town, or county) (State) Carroll Co Md

23. FUNERAL DIRECTOR'S SIGNATURE Edw S Tipton ADDRESS Hampstead Md
24a REC'D BY REGISTRAR DATE JUN 20 '60
24b REGISTRAR'S SIGNATURE Clinton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

06757

CERTIFICATE OF DEATH

6791 Item 1c Film 266 7-5-50 et

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 8 Mon. 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hosp.

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1939 Dineen Drive,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: Gerald GESELL — Last: Jr.

4. DATE OF DEATH: Month: June — Day: 25, — Year: 19 60

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 9-3-07
9. AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electric Welder
10b. KIND OF BUSINESS OR INDUSTRY: Renneberg Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Arthur G. Gessell, Sr.
14. MOTHER'S MAIDEN NAME: Louise Israel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: 213-10-6336
17. INFORMANT: Springfield State Hosp. Records — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b): Arteriosclerotic heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Arteriosclerosis

I 20.1

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS Assoc. with cerebraler arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10-19-59 19___, to 6-25-60 19___, that (I) (we) last saw the deceased alive on 6-25-60 19___, and that death occurred at 6:10 A.M. from the causes and on the date stated above

22a. SIGNATURE: Ellis L. Margolin M.D
ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 6-26-60
22c. PHYSICIAN'S NAME (Type): Dr. Ellis Margolin
22d. ADDRESS: Springfield State Hosp, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/28/60
23c. NAME OF CEMETERY OR ~~CREMATORY~~: OAK LAWN
23d. LOCATION (City, town, or county) (State): Balto Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. W. Hoffmann — ADDRESS: 3218 Hudson St.
25a. REC'D BY REGISTRAR DATE: JUN 28 '60
25b. REGISTRAR'S SIGNATURE: Clifton S. Kramer

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

Item 1c Film 274 1-1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6792

6C758

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 8mos.27days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1703 Aliceanna Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: ; Last: Gessler

4. DATE OF DEATH: Month: June; Day: 19,; Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Sept. 11, 1902

9. AGE (In years last birthday): 57 yrs
IF UNDER 1 YEAR / IF UNDER 24 HRS: Months; Days; Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oiler

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Gessler

14. MOTHER'S MAIDEN NAME: Ella Fin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pulmonary tuberculosis, far advanced, active — INTERVAL BETWEEN ONSET AND DEATH: years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
023X
DUE TO (b): 1. Arteriosclerotic cardiovascular disease
DUE TO (c): 2. Late latent syphilis.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with alcoholism, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 22, 1959 to June 19, 1960 that (I) (we) last saw the deceased alive on ____ 19___, and that death occurred at 10:50 P.M. from the causes and on the date stated above

22a. SIGNATURE: Ellis S. Margolin M.D.
ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 6/20/60

22c. PHYSICIAN'S NAME (Type): Ellis S. Margolin, M.D.
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 24 1960
23c. NAME OF CEMETERY OR CREMATORY: Springfield Hospital Cemetery
23d. LOCATION (City, town or county) (State): Baltimore Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Frank C. Kendall — ADDRESS: Sykesville, Md.

25a. RECD BY REGISTRAR DATE: JUN 27 '60

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS AISME
BM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6793 06759 Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Sykesville, Md
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospial

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 325 Williams Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle Junior — Last Hamilton
4. DATE OF DEATH: Month June — Day 9, — Year 1960

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 1-29-21
9. AGE (In years last birthday): 39 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accpuntin; C;erk
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland Cumberland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James H. Hamilton
14. MOTHER'S MAIDEN NAME: Bertie Margaret Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): 1942-45
16. SOCIAL SECURITY NO.: 214-12-3809
17. INFORMANT (Address): Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Suffocation by hanging — INTERVAL BETWEEN ONSET AND DEATH
1774 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): ___ DUE TO (c): ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, cnronic undifferentiated type
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): By hanging
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 6-9-60 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital grounds,
20f. (City or town) Sykesville, (County) Carroll, (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D
EXAMINER'S NAME (Type): James T. Marsh
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6-9-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 12, 1960
22c. NAME OF CEMETERY OR CREMATORY: Mt. Herman Cemetery
22d. LOCATION (City, town, or county) Allegany County, (State) Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer
ADDRESS: Cumberland Md
24a. REC'D BY REGISTRAR DATE: JUN 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Friend

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6794

CERTIFICATE OF DEATH

06766

1 PLACE OF DEATH
a. COUNTY Carroll MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick 125

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville

c. LENGTH OF STAY IN 1b 4yrs,17 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville

d. NAME OF HOSPITAL OR INSTITUTION Springfield State Hospital.

d. STREET ADDRESS Myersville,Maryland.

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First William Middle Eugene Last Hauver

4. DATE OF DEATH Month 6 Day 5 Year 1960

5. SEX Male

6. COLOR OR RACE White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH 3-2-1886

9. AGE (In years last birthday) 74 yrs

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS: Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher (retired)

10b. KIND OF BUSINESS OR INDUSTRY Fred.Co.Schools

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thaddeus Hauver

14. MOTHER'S MAIDEN NAME Charlotte Routzahn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes give war or dates of service) Lt.Army 1917-18

16. SOCIAL SECURITY NO none

17. INFORMANT Hospital records Address Sykesville,Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia.

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. ass.with cerebral arterrosclerosis,with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month Day Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-18 - 1956 to 6-5 1960, that (I) (we) last saw the deceased alive on 6-5- 1960, and that death occurred at 9.53 A.M., from the causes and on the date stated above.

22a. SIGNATURE Agustin del Campo M.D.

ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS [X]

22b. DATE SIGNED 6-5-60

22c. PHYSICIAN'S NAME (Type) Agustin del Campo.M.D.

22d. ADDRESS Springfield State Hospital Sykesville,Md.

23a. BURIAL CREMATION REMOVAL (Specify) Burial

23b. DATE THEREOF 6-7-60

23c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran

23d. LOCATION (City, town, or county) (State) Myersville, Fred.Co.Md.

24. FUNERAL DIRECTOR'S SIGNATURE Paul F. Buell ADDRESS Myersville Md

25a. REC'D BY REGISTRAR DATE JUN 7 '60

25b. REGISTRAR'S SIGNATURE Clifton S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6795

CERTIFICATE OF DEATH

0676

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kitzmiller
d. STREET ADDRESS: ———
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: C. — Last: Iman
4. DATE OF DEATH: Month: June — Day: 6 — Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 8, 1892
9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Time Inspector
10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Edgar Iman
14. MOTHER'S MAIDEN NAME: Hester Yount
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): ———
16. SOCIAL SECURITY NO: 213-07-7603
17. INFORMANT: Springfield Hospital Records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary insufficiency — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO
(b): Arteriosclerotic heart disease — years
DUE TO
(c): Generalized arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute Brain Syndrome of unknown cause.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 28, 1960, to June 6, 1960, that (I) (we) last saw the deceased alive on June 6, 1960, and that death occurred at 11:50 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: June 6, 1960
22c. PHYS C AN'S NAME (Type): Agustin del Campo, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-9-60
23c. NAME OF CEMETERY OR CREMATORY: Oakland
23d. LOCATION (City, town or county) (State): Oakland Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert Butts — ADDRESS: Kitzmiller, Md.
25a. REC'D BY REGISTRAR — DATE: JUN 10 '60
25b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06762

1 PLACE OF DEATH a. COUNTY: 6796 Carroll — MARYLAND
2. USUAL RESIDENCE (Where deceased lived If institution Res dence before admission) a. STATE: Maryland b. COUNTY: Baltimore city
b. CITY OR TOWN (If outside corporate limits, write RURAL and g ve nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 26 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital
d. STREET ADDRESS: 5 N. Exeter Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lambert Middle W. Last Johnson
4. DATE OF DEATH: Month June Day 28 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ------ Unknown
10b. KIND OF BUSINESS OR INDUSTRY: ------ Unknown
11. BIRTHPLACE (State or foreign country): ---------- Unknown
12. CITIZEN OF WHAT COUNTRY? ☒ U.S.A.
13. FATHER'S NAME: -------- Unknown
14. MOTHER'S MAIDEN NAME: -------- Unknown
15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no or unknown) ------ (If yes, give war or dates of service) ------
16. SOCIAL SECURITY NO. --------
17. INFORMANT Address: Springfield Hospital Records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laennec's Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER S GNIF CANT CONDITIONS CONTRIBUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART 1(a): ABS associated with alcoholism
19. WAS A JTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg , etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from June 2, 1960 to June 28, 1960, that (I) (we) last saw the deceased alive on June 28, 1960, and that death occurred at 8:50 P.M. from the causes and on the date stated above

22a SIGNATURE: Ellis S. Margolin M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: June 29, 1960
22c. PHYSICIAN'S NAME (Type): Ellis S. Margolin
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7-1-60
23c. NAME OF CEMETERY OR CREMATORY: New Cathedral
23d. LOCATION (City town or county) (State): Baltimore, Md.
24 FUNERAL DIRECTOR S SIGNATURE ADDRESS: [illegible] Md.
25a. REC'D BY REGISTRAR DATE JUL 7 '60
25b REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6797 Item 1 ...

06763

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 20 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XXXXXXXXX Towson 4
d. STREET ADDRESS: 8521 Willow Oak Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) — First: Rose — Middle: Mary — Last: Kaufer

4. DATE OF DEATH — Month: June — Day: 6 — Year: 1960

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: February 19, 1876

9 AGE (In years last birthday): 84 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ———

11 BIRTHPLACE (State or foreign country): Pennsylvania

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: XXXXXXXXXX Martin Bauer

14 MOTHER'S MAIDEN NAME: Catherine Scheidt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO: ———

17 INFORMANT — Address: Springfield Hospital Records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Arteriosclerotic cardiovascular disease	years
DUE TO (b)	Generalized arteriosclerosis	years
DUE TO (c)		

433.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS associated with cerebral arteriosclerosis, with psychotic reaction.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 — Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from May 16 1960 to June 6, 1960, that (I) (we) last saw the deceased alive on June 6, 1960, and that death occurred at 10:45 a.m. from the causes and on the date stated above

22a SIGNATURE: Agustin del Campo M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b DATE SIGNED: June 6, 1960

22c PHYSICIAN'S NAME (Type): Agustin del Campo

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 6-9-60

23c NAME OF CEMETERY OR CREMATORY: Prospect Hill

23d LOCATION (City, town, or county) (State): Towson 4, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Brooks Funeral Service, Towson 4, Md.

25a. REC'D BY REGISTRAR — DATE: JUN 9 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be ...ed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within ... hours after death.

Page 4

VR A15 (4)
15M 9/59

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6774

CERTIFICATE OF DEATH

06764
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 19 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Westminster
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —
d. STREET ADDRESS: 49 W. Green Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: Thomson; Last: Knode

4. DATE OF DEATH: Month: June; Day: 18; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 7, 1871

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Jacob Thomson

14. MOTHER'S MAIDEN NAME: Mary Robison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: —

17. INFORMANT: Address: Mrs. J. T. Knode, Woodstock, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Vascular Renal — INTERVAL BETWEEN ONSET AND DEATH: Several yrs
DUE TO (b): disease, myocardial degeneration & Valvular
DUE TO (c): Arterio Sclerosis General

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: — o. m. p. m. Month: — Day: — Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —

20f. (City or town) (County) (State): —

21. I certify that I attended the deceased from April, 1959 to June 18, 1960, that I last saw the deceased alive on June 18, 1960, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. W. Lem Speicher — ADDRESS (Street, city or town, state): Westminster Md — DATE SIGNED: 6/20/60

PHYSICIAN'S NAME (Type): —

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 21, 1960

22c. NAME OF CEMETERY OR CREMATORY: Westminster Cemetery

22d. LOCATION (City, town, or county) (State): Westminster Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers — ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR DATE: JUN 22 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6798

CERTIFICATE OF DEATH

0C765

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1. PLACE OF DEATH — a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Md. — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dr. John — Middle: B. — Last: Horner

4. DATE OF DEATH: Month: June — Day: 10 — Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-12-1879

9. AGE (In years last birthday): 81 yrs

IF UNDER 1 YEAR: Months: / Days: / — IF UNDER 24 HRS: Hours: / Min.: /

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician

10b. KIND OF BUSINESS OR INDUSTRY: Doctor, surgeon

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: J. T. Horner, Sr.

14. MOTHER'S MAIDEN NAME: Virginia Kelly

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): ? — (If yes give war or dates of service):

16. SOCIAL SECURITY NO: /

17. INFORMANT — Address: Mt. Travilla, Horner Residence, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary thrombosis, Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 1959 to 10 June 60

DUE TO (b): arteriosclerotic heart disease,

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): arteriosclerosis generalized

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): /

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED — While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1959 19 to 10 June, 1960, that (I) (we) last saw the deceased alive on 10 June 1960 and that death occurred at 2:? P.M., from the causes and on the date stated above.

22a. SIGNATURE: Howard E Hall M.D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11 June 60

22c. PHYSICIAN'S NAME (Type): H. Ward E. Hall

22d. ADDRESS: Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-13-60

23c. NAME OF CEMETERY OR CREMATORY: Springfield

23d. LOCATION (City, town, or county) (State): Westminster, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible] Sykesville, Md.

25a. REC'D BY REGISTRAR — DATE: JUN 16 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kuhns

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6799

CERTIFICATE OF DEATH

0676

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Sykesville
c LENGTH OF STAY IN 1b: 7yrs.6mos.4days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Res dence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 29
d STREET ADDRESS: 111 Allendale St.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Doris — Middle: Marie — Last: Markland

4. DATE OF DEATH: Month: June — Day: 30, — Year: 1960

5 SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Sept. 3, 1929
9. AGE (In years last birthday) yrs: 30
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None.
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lawrence Markland
14. MOTHER'S MAIDEN NAME: Ruth Harcourt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Far advanced pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, catatonic type, in a mental defective.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Dec. 26, 1952, to June 30, 1960, that (I) (we) last saw the deceased alive on June 30, 1960, and that death occurred at 1:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Ellis S. Margolin M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 6/30/60
22c PHYSICIAN'S NAME (Type): Ellis S. Margolin, M.D.
22d. ADDRESS

23a BURIAL CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 7/2/60
23c. NAME OF CEMETERY OR CREMATORY: Balto Nat'l Cem
23d. LOCATION (City, town, or county) (State): Balto —

24. FUNERAL DIRECTOR'S SIGNATURE: Streckfuss & Son
ADDRESS: 501 E. 22nd St.

25a REC'D BY REGISTRAR DATE: JUL 6 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6800

CERTIFICATE OF DEATH

0C767

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH — a COUNTY: Carroll — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c LENGTH OF STAY IN 1b: 10 years
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a STATE: Md. — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BOYD — Middle CUMMINGS — Last METCALF, Sr.
4. DATE OF DEATH: Month June — Day 9 — Year 1960
5. SEX: M
6 COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Jan. 1, 1875
9 AGE (In years last birthday): 85 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Overseer
10b KIND OF BUSINESS OR INDUSTRY: Hooper Cotton Mills
11 BIRTHPLACE (State or foreign country): Md.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Leonard T. Metcalf
14 MOTHER'S MAIDEN NAME: Catherine Hamilton

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 213-03-7522
17. INFORMANT — Address: Mrs. Lindell Metcalf - Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CHRONIC HYPERTENSIVE CARDIOVASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH:

443x

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last

(b) WITH ARTERIOSCLEROSIS AND MYOCARDITIS; — 20 yrs.

DUE TO

(c) Chronic glomerulonephritis — same

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ADVANCED SENILE CHANGES AND DETERIORATION

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from 1935 19___ to 6/9/60 19___ that (I) (we) last saw the deceased alive on 6/9/60 19___ and that death occurred at 4:10 AM from the causes and on the date stated above

22a SIGNATURE: Wm H Lawson M D
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 6/9/60
22c PHYSICIAN'S NAME (Type): Wm. H. Lawson, Jr., M.D.
22d. ADDRESS: Sykesville P.O., Maryland

23a BURIAL, CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 6-12-60
23c NAME OF CEMETERY OR CREMATORY: St Paul's Methodist
23d LOCATION (City, town, or county) (State): Granite, Balto. Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight — ADDRESS: Sykesville, Md.
25a REC'D BY REGISTRAR — DATE: JUN 14 '60
25b REGISTRAR'S SIGNATURE: Arthur S Kines

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

0676

6801

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH — a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Penna. — b. COUNTY: Adams

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Sykesville

c. LENGTH OF STAY IN 1b: 4 Weeks

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Littlestown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Golden Age Guest Home, Sykesville, Md. R-2

d. STREET ADDRESS: N. Queen Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Simon — Middle: Frank — Last: Miller

4. DATE OF DEATH: Month: 6/10/60 — Day — Year: 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/30/1880

9. AGE (In years last birthday): 79 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Adams Co., Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Simon Miller

14. MOTHER'S MAIDEN NAME: Ella Sheely

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 219-30-8486

17. INFORMANT: Melvin A. Miller, Littlestown, Pa. — Address: 349 Lumber St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiac Arrest

DUE TO (b): Acute Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Years: 7

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1 19 60 to June 10 19 60, that (I) (we) last saw the deceased alive on June 9 19 60 and that death occurred at ___ M, from the causes and on the date stated above.

22a. SIGNATURE: M. M. Martin — M D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): M. M. MARTIN M.D.

22d. ADDRESS: Littlestown Pa.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/12/60

23c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery

23d. LOCATION (City, town, or county) (State): Littlestown, Adams Co., Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: Richard A. Little — ADDRESS: Littlestown, Pa.

25a. REC'D BY REGISTRAR — DATE: JUN 13 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6802

0676;

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 34yrs.4mos.17days

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 15, D.C.
d. STREET ADDRESS: 6148 31st St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

3. NAME OF DECEASED (Type or print): First John — Middle F. — Last O'Brien

4. DATE OF DEATH: Month June — Day 13 — Year 1960

5 SEX: Male
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: October 1, 1881
9 AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Matthew O'Brien
14. MOTHER'S MAIDEN NAME: Annie Stearn

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO ———
16 SOCIAL SECURITY NO.: ———
17 INFORMANT Address: Springfield Hospital Records, Sykesville, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: years
00 2X
DUE TO
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized Arteriosclerosis — years
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, other and unspecified.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (X) (this hospital) attended the deceased from January 26 1926, to June 13, 1960, that (I) (we) last saw the deceased alive on June 12 1960, and that death occurred at 6 A.M. from the causes and on the date stated above.

22a SIGNATURE: Ellis S. Margolin M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: June 13, 1960
22c PHYSICIAN'S NAME (Type): Ellis S. Margolin, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a BURIAL CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 6/15/60
23c NAME OF CEMETERY OR CREMATORY: St.Mary's Cemetery
23d LOCATION (City, town, or county) (State): Rockville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: JUN 15 '60
25b REGISTRAR'S SIGNATURE: Arthur J. Klaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6803

CERTIFICATE OF DEATH

06770

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 5 mos. 20 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1703 Sherwood Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: Elizabeth; Last: Peacock

4. DATE OF DEATH: Month: June; Day: 21; Year: 1960

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
Female	White	MARRIED ☒	August 26, 1885	74 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	----------	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James M. Boston	Susie E. Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
NO	--------	NONE	Springfield Hospital Records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: weeks

DUE TO (b): Generalized arteriosclerosis — years

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS assoc. cerebral arteriosclerosis, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19	20d. INJURY OCCURRED: While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from January 1, 1960, to June 21, 1960, that (I) (we) last saw the deceased alive on June 21, 1960, and that death occurred at 11:30 P. M., from the causes and on the date stated above.

22a. SIGNATURE: Ellis S. Margolin M.D — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒ — 22b. DATE SIGNED: June 21, 1960

22c. PHYSICIAN'S NAME (Type): Ellis S. Margolin, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL CREMATION REMOVAL (Specify)

23b. DATE THEREOF: 6-24-60

23c. NAME OF CEMETERY OR CREMATORY: Parkwood

23d. LOCATION (City, town, or county) (State): Balto Md

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Leonard J Luck 5305 Harford

25a. REC'D BY REGISTRAR: JUN 22 '60

25b. REGISTRAR'S SIGNATURE: Carlton S. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0C77

CERTIFICATE OF DEATH

6775 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
c. LENGTH OF STAY IN 1b 54 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Church St

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
d. STREET ADDRESS 37 Webster St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First BERTHA Middle MAY Last POOLE
4. DATE OF DEATH Month JUNE Day 1 Year 19 60

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH May 10, 1889
9. AGE (In years last birthday) 70 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Balto. Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Benjamin C. Poulson
14. MOTHER'S MAIDEN NAME Cora Hoff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
INFORMANT Address Mrs. H. Pole, 37 Webster St Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Cardiovascular disease with hypertension — 5-10 yrs
DUE TO (c) Arthritis General — 10 yrs or more

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1957 to June 1, 1960 that I last saw the deceased alive on May 30, 1960 and that death occurred at 6:10 A.M. from the causes and on the date stated above
ACTUAL SIGNATURE W. Leland Speicher ADDRESS (Street, city or town, state) Westminster md DATE SIGNED 6/1/60
PHYSICIAN'S NAME (Type)

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF 6/4/60
22c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State) Westminster Md RD

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. J. Hoops Jr. Westminster Md
24a REC'D BY REGISTRAR DATE JUN 3 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6805

Reg. Dist. No. 0677

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b 3 Months
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) Golden Age Guest House — Woodbine Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d STREET ADDRESS 2624 E.Joppa Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First AGATA Middle Last Quintiliani
4. DATE OF DEATH Month June Day 28 Year 1960

5 SEX Female
6. COLOR OR RACE White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Feb.5 1915
9 AGE (In years last birthday) 45 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11 BIRTHPLACE (State or foreign country) Penna S.Andrea-Italy
12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME Michele Violante
14. MOTHER'S MAIDEN NAME Eugenia Della Noce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Address William Quintiliani 2624 E.Joppa Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Sclerosis — INTERVAL BETWEEN ONSET AND DEATH 2 yrs
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 23, 1960 to June 28, 1960 that I last saw the deceased alive on June 28, 1960, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE Harold D. Mastin M.D.
ADDRESS (Street, city or town, state) Sykesville Md
DATE SIGNED
PHYSICIAN'S NAME (Type) HAROLD D. MASTIN

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF July 1st 60
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.
22d LOCATION (City, town, or county) (State) 4430 Belair Rd. Balt. Md.

23. FUNERAL DIRECTOR'S SIGNATURE Grant Della Noce
ADDRESS 322 S.High St
24a. REC'D BY REGISTRAR DATE JUN 30 '60
24b. REGISTRAR'S SIGNATURE Arthur L. Kuhn

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6804

CERTIFICATE OF DEATH

Reg Dist No. 16773

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westminster
c. LENGTH OF STAY IN 1b 30yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Snydersburg Rd.

2. USUAL RESIDENCE (Where deceased lived. If inst tution, Residence before admission)
a. STATE Maryland
b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westminster - R.D. 3.
d. STREET ADDRESS Snydersburg Rd
e. IS RESIDENCE ON A FARM? YES X NO ☐

3. NAME OF DECEASED (Type or print) First Alma Middle A. Last Rhoten.

4. DATE OF DEATH Month June Day 20, Year 1960

5. SEX F

6. COLOR OR RACE W

7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Febr. 12 1904

9. AGE (In years last birthday) 56 yrs

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) Millers Md. R.D.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William H. Fourhman

14. MOTHER'S MAIDEN NAME Minerva Rosier-

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT Address Wilbert A. Rhoten, Westminster Md. R.D. 3.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Disease

204.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 19 5[illegible], to June 19 6[illegible], that I last saw the deceased alive on June 18, 1960, and that death occurred at 5:40 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE [illegible] M.D. Westminster, Md. June 21 60

PHYSICIAN'S NAME (Type) [illegible] Westminster, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF June 23, 1960

22c. NAME OF CEMETERY OR CREMATORY Stiltz Cemetery

22d. LOCATION (City, town, or county) (State) Glen Rock, Penna. R.D. 3.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jacob Martenstein, New Freedom, Pa.

24a. REC'D BY REGISTRAR DATE JUN 22 '60

24b. REGISTRAR'S SIGNATURE Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
TSM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6806 [illegible] 06774

1

1 PLACE OF DEATH a. COUNTY: Carroll, MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville

c. LENGTH OF STAY IN 1b: 5 Mos.18Days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Baltimore City

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore [illegible]

d. STREET ADDRESS: 412 Ilchester Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: Annie Middle: Elizabeth Last: Robertson

4 DATE OF DEATH Month: June Day: 22 23 Year: 1960

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: January 6, 1907

9 AGE (In years last birthday): 53 yrs IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY: --------

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Clarence A. Bowers

14. MOTHER'S MAIDEN NAME: Sarah Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): -------

16. SOCIAL SECURITY NO.: ------

17 INFORMANT / Address: Springfield Hospital Records, Sykesville, Md.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bilateral bronchopneumonia	Days
DUE TO (b) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	Tumor of the orbital area of the brain	Years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS. of Unknown or unspecified cause with psychotic reaction

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from January 6 5 1960 to June 23, 1960 that (I) (we) last saw the deceased alive on June 22, 1960 and that death occurred at 8:15 a.m. from the causes and on the date stated above.

22a SIGNATURE: [illegible signature] M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: June 23, 1960

22c PHYSICIAN'S NAME (Type): Ellis S. Margolin, M.D.

22d ADDRESS: Springfield Hospital, Sykesville, Md.

23a BURIAL, CREMATION REMOVAL (Specify): Burial

23b DATE THEREOF: 6-25-1960

23c NAME OF CEMETERY OR CREMATORY: Brandenburg Cemetery

23d LOCATION (City, town, or county) (State): Carroll Co. , Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: C.M. Waltz, ADDRESS: Winfield , Maryland

25a REC'D BY REGISTRAR DATE: JUN 27 '60

25b REGISTRAR'S SIGNATURE: [illegible signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6807

CERTIFICATE OF DEATH

06775

Reg. Dist. No. .....

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY Carroll Co. — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge City

LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS --

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Carroll

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge

STREET ADDRESS (If rural give location) 4 Elm St

3. NAME OF DECEASED (Type or Print) — (First) Rachel (Middle) Anna (Last) Smith

4. DATE OF DEATH (Month) 6 (Day) 13 (Year) 19 60

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	B	Widowed	Jan 15, 1871	89 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carroll

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John White

14. MOTHER'S MAIDEN NAME: Elizabeth Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Mrs. Smith Union Bridge Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 IMMEDIATE CAUSE (A) Chronic Myocarditis

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Arteriosclerosis DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan —, 1960, to 6-12-, 1960, that I last saw the deceased alive on 6-12-, 1960, and that death occurred at 10:15 M, from the causes and on the date stated above.

SIGNATURE J N Legg M.D. ADDRESS (Street, city, town, state) Union Bridge DATE SIGNED 6-13-60

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	June 15 '60	Woodside Memorial Park	Westminster, Md.

24. REC'D BY REGISTRAR DATE JUN 15 '60

REGISTRAR'S SIGNATURE Arthur B. Haines

25. FUNERAL DIRECTOR'S SIGNATURE Reginald F. Ingram Westminster, Md. ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6808

CERTIFICATE OF DEATH

0677o

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 6 mos. 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore city
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 104 N. Greene Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leona; Middle: Ann; Last: Sook

4. DATE OF DEATH: Month: June; Day: 7; Year: 1960

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: February 23, 1912
9 AGE (In years last birthday): 48 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b KIND OF BUSINESS OR INDUSTRY: **********
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ----------
14. MOTHER'S MAIDEN NAME: ----------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO: 530-16-4364
17 INFORMANT Address: Springfield Hospital Records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO
(b): Huntington's Chorea — years
DUE TO
(c):

355X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome, unknown, unspecified cause, with psychotic react.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year, Hour a. m. p. m.
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from November 25, 19 59, to June 7, 1960, that (I) (we) last saw the deceased alive on June 6, 1960, and that death occurred at 3:37 P.M. from the causes and on the date stated above

22a SIGNATURE: Agustin del Campo M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: June 7, 1960
22c. PHYSICIAN'S NAME (Type): Agustin del Campo
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)
23b DATE THEREOF: 6-9-60
23c NAME OF CEMETERY OR CREMATORY: No 6 pm Greenmount Cemetery
23d LOCATION (City, town, or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Frank H Purnell
ADDRESS: Sykesville Md
25a. REC'D BY REGISTRAR DATE: JUN 13 1960
25b. REGISTRAR'S SIGNATURE: Catherine L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6809

CERTIFICATE OF DEATH

06777

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 18yrs.2mos.19days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Thurmont
d. STREET ADDRESS: RFD #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nora; Middle: Matilda; Last: Speak

4. DATE OF DEATH: Month: June; Day: 27; Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: ~~Unknown~~ 1-13-98
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS: Months; Days; Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Louisiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Unknown~~ James Shook
14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Anna Mary Hovis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes give war or dates of service): -
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Springfield Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — Interval between onset and death: Years

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause ost

DUE TO (b): Septicemia — Days

DUE TO (c): Lymphangitis — Days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, paranoid type

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m p. m; Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 8, 1942, to June 27, 1960, that (I) (we) last saw the deceased alive on June 26, 1960, and that death occurred at 7:15 AM/PM from the causes and on the date stated above

22a SIGNATURE: Ellis S. Margolin M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: 6/27/60
22c. PHYSICIAN'S NAME (Type): Ellis S. Margolin, M.D.
22d ADDRESS: Springfield Hospital, Sykesville, Md.

23a BURIAL CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 6-30-60
23c. NAME OF CEMETERY OR CREMATORY: Blue Ridge Cemetery
23d LOCATION (City town, or county) (State): Thurmont, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond E. Creager
ADDRESS: Thurmont, Md.
25a REC'D BY REGISTRAR DATE: JUL 1 '60
25b REGISTRAR'S SIGNATURE: Arthur S. Kranz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6810 **CERTIFICATE OF DEATH** 06774

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 5 days after death.

VR A1S (4)
1SM 9/59

1 **PLACE OF DEATH** a. COUNTY: Carroll — MARYLAND

2 **USUAL RESIDENCE** (Where deceased lived. If institution Residence before admission) a. STATE: Maryland b. COUNTY: Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Westminster

c. LENGTH OF STAY IN 1b: Life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Westminster

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Westminster, R. D. 3

d. STREET ADDRESS: Westminster, R. D. 3

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Frank Middle: T. Last: Stewart

4. **DATE OF DEATH**: Month: 6/5/60 Day: Year: 19

5 SEX: Male

6 COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8 DATE OF BIRTH: 8/27/1881

9 AGE (In years last birthday): 78 yrs

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b KIND OF BUSINESS OR INDUSTRY: His own farm

11. BIRTHPLACE (State or foreign country): Carroll Co., Md.

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Stewart

14. MOTHER'S MAIDEN NAME: Barbara Wisner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

17 INFORMANT: Malcolm F. Stewart, Westminster, Md. R-3 Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Heart attack — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

DUE TO (b): Uremia Sclerosis Generalized — 10 Yrs

DUE TO (c): Prostatic Cancer — 5 Yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Prostatectomy Carcinoma Hernia Inguinal — 19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from June 19 60 to 6 5 60 19 ___, that (I) (we) last saw the deceased alive on 6 4 19 60, and that death occurred at 8:15 PM, from the causes and on the date stated above

22a. SIGNATURE: George E Thomessy M.D. — ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ] — 22b. DATE SIGNED: 6.6.60

22c PHYSICIAN'S NAME (Type): George E Thomessy

22d. ADDRESS: Hanover Pa

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 6/8/60

23c NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d LOCATION (City, town, or county) (State): Hanover, York Co., Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: Richard A Little ADDRESS: Littlestown, Pa.

25a. REC'D BY REGISTRAR DATE: JUN 7 '60

25b REGISTRAR'S SIGNATURE: Arthur L. Frank

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6811 06779

CERTIFICATE OF DEATH

Film G264 6-10-60 et

1 PLACE OF DEATH a. COUNTY Baltimore (Carroll County) MARYLAND — Weltzel Nursing Home

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission.) a. STATE Md. — b. COUNTY Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine, Carroll Co. — c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown, Md.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weltzel Nursing Home — d. STREET ADDRESS 3309 Offutt Rd. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First LOUISA Middle W. Last SUDMAN — 4. DATE OF DEATH Month 6 Day 2 Year 1960

5. SEX F — 6. COLOR OR RACE W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH Apr 10, 1883 — 9. AGE (In years last birthday) 77 yrs — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) Randallstown, Md. — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John D. Sudman — 14. MOTHER'S MAIDEN NAME Louisa Leutze

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Address Mrs. J. Scott Sudman

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral fracture, cerebro-brain

DUE TO (b) Cerebral disease, Chronic brain Syndrome

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c) Carcinoma breast (removed) metastasis

INTERVAL BETWEEN ONSET AND DEATH: (a) 17 hrs (b) 3 yrs (c) 2 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1959 19__ to 2 June 19 60 that (I) (we) last saw the deceased alive on 2 June 19 60 and that death occurred at 2:24 P.M., from the causes and on the date stated above

22a. SIGNATURE Howard C. Hall M.D. — ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) — 22d. ADDRESS Upperville, Va.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 23b. DATE THEREOF 6-6-1960 — 23c. NAME OF CEMETERY OR CREMATORY Mt Olive Cem. — 23d. LOCATION (City, town, or county) (State) Randallstown Md.

24. FUNERAL DIRECTOR'S SIGNATURE Young Byers — ADDRESS 8728 Liberty Rd. Randallstown, Md.

25a. REC'D BY REGISTRAR DATE JUN 7 '60 — 25b. REGISTRAR'S SIGNATURE Catherine S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6812

CERTIFICATE OF DEATH

0678

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 48yrs.10mos.3days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore city
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore, Maryland
d. STREET ADDRESS: 2660 Presberry Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Benjamin — Middle: A. — Last: Tall

4. DATE OF DEATH: Month: June — Day: 10 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1873

9. AGE (In years last birthday): ~~82~~ 86

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sailor

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin F. Tall

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arter iosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

420.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenia, paranoid type.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from February 8, 1912, to June 10, 1960, that (I) (we) last saw the deceased alive on June 9 1960, and that death occurred at 3:15 a.m. from the causes and on the date stated above

22a. SIGNATURE: Agustin del Campo M.D

ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: June 10, 1960

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): 6-13-60

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: V.A.M. Anatomy Board

23d. LOCATION (City, town, or county) (State): Baltimore, Md

24. FUNERAL DIRECTOR'S SIGNATURE: Frank H. Mundell — ADDRESS

25a. REC'D BY REGISTRAR DATE: JUN 15 '60

25b. REGISTRAR'S SIGNATURE: S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6813 (16781)

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural, Sykesville
c. LENGTH OF STAY IN 1b: 5y 2m 27days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hoopersville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Nora — Middle: Tyler — Last: Traverse

4. DATE OF DEATH: Month: June — Day: 28 — Year: 1960

5 SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
female	white		8/30/75	84 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	USA

13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
James Tyler	Susan Hooper

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT Address
No		Springfield Hospital records, Sykesville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic degenerative Myocardotis. — INTERVAL BETWEEN ONSET AND DEATH: YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): A.S.C.V.D. — YEARS
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome assoc. with senile brain disease with psychosis.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify that** ☒ (this hospital) attended the deceased from 3/31/ 19 55 to 6/28/ 1960, that ☐ (we) last saw the deceased alive on 6/28/ 19 60, and that death occurred at 3:30 P.m. from the causes and on the date stated above.

22a SIGNATURE: Konstantin Weber M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b DATE SIGNED: 6/28/60

22c PHYSICIAN'S NAME (Type): Konstantin Weber, M. D.

22d ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a BURIAL CREMATION REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City, town or county) (State)
Burial	July 6, 1960	Rochester Memorial Park	Cambridge Maryland

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a RECEIVED BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
L. E. Compton Funeral Dir.	Cambridge Md.	JUL 1 '60	Arthur S. Fraser

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6814

CERTIFICATE OF DEATH

06782

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hydesville
c. LENGTH OF STAY IN 1b: 3 Weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sunnyview Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE: Md. b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Hydesville
d. STREET ADDRESS: Oakland Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle ANNA Last TRATT

4. DATE OF DEATH: Month June Day 2 Year 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Feb. 25, 1893

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: J. Robert Hughes

14. MOTHER'S MAIDEN NAME: Mary E. Stevenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT Address: Mr. Watson Tratt - Sykesville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pneumonia, lobar, bilateral, acute, causative organism undetermined	4 days
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Hypertensive cardiovascular disease with arteriosclerosis and chronic myocarditis	20 yrs.
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): hypertrophic arthritis, chronic; cholescystitis, chronic

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1935 19 to 6/2/60 19, that (I) (we) last saw the deceased alive on 6/1/60 19, and that death occurred at 4:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Wm. H. Lawson Jr. M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6.2.60

22c. PHYSICIAN'S NAME (Type): Wm. H. Lawson, Jr., M.D.

22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6 5 60

23c. NAME OF CEMETERY OR CREMATORY: New Windsor

23d. LOCATION (City, town, or county) (State): Westminster, Carroll Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Paul H. Haight — **ADDRESS**: Sykesville, Md.

25a. REC'D BY REGISTRAR DATE JUN 7 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Harris

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6815 06783

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
c. LENGTH OF STAY IN 1b 50 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
d. STREET ADDRESS Mineral Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First CAROLINE (CARRIE) Middle E. Last WILLIAMS

4. DATE OF DEATH Month June Day 16 Year 1960

5. SEX F. 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH Oct 16 1883 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME John Ware 14. MOTHER'S MAIDEN NAME Ella Richardson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. 17. INFORMANT Address Mr John H. Williams Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure, Aneurysm aorta, — INTERVAL BETWEEN ONSET AND DEATH 15 Yrs

DUE TO (b) arteriosclerotic heart dis., arteriosclerosis — to

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0

DUE TO (c) pneumonia, bronchial pneumonia — 16 June 60

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 1956 19 to 16 June 19 60, that (I) (we) last saw the deceased alive on 16 June 1960, and that death occurred 8 A M, from the causes and on the date stated above.

22a. SIGNATURE Howard E. Hall M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 16 June 60

22c. PHYSICIAN'S NAME (Type) HOWARD E. HALL 22d. ADDRESS Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 6-18-60 23c. NAME OF CEMETERY OR CREMATORY Mt Union 23d. LOCATION (City, town, or county) (State) Carroll Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE Luther H. Haight ADDRESS Sykesville, Md. 25a. REC'D BY REGISTRAR DATE JUN 21 '60 25b. REGISTRAR'S SIGNATURE Arthur L. Norris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6776 Reg. Dist. No. 06784

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
c. LENGTH OF STAY IN 1b 47 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 339 E. Main St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Westminster
d. STREET ADDRESS 339 E. Main St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ERVIN Middle ELIAS Last ZAHN
4. DATE OF DEATH Month JUNE Day 15 Year 1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M.	White		March 15, 1913	47 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cafeteria Operator	Clothing factory	Westminster Md	U.S.A

13. FATHER'S NAME Paul Emma Zahn
14. MOTHER'S MAIDEN NAME Stella Beaver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-01-1766
17. INFORMANT Mrs. Stella B. Zahn Address 339 E. Main St Westminster Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardis (Acute) — INTERVAL BETWEEN ONSET AND DEATH 30 days
DUE TO (b) Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 444X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 5-15-1960 to 6-15-1960, that I last saw the deceased alive on 6-15-60, and that death occurred at 9:15 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Wm C. Jennette M.D. ADDRESS (Street, city or town, state) 103 E Main Westminster Md DATE SIGNED 6-15-60
PHYSICIAN'S NAME (Type) W.C. Jennette MD Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	6/18/60	Rowes Cemetery	Rural Westminster Md

23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers Jr. ADDRESS Westminster Md
24a. REC'D BY REGISTRAR DATE JUN 17 '60
24b. REGISTRAR'S SIGNATURE Cecil E. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55